

# CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D

Work Telephone \_\_\_\_\_ # Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Your E-mail Address \_\_\_\_\_

Name and Address of Employer \_\_\_\_\_ Health Administrator's Name \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous chiropractic care?  Yes  No

Main Complaint \_\_\_\_\_

Other Complaints \_\_\_\_\_

Are you pregnant?  Yes  No

Are you taking any medication?  Yes  No If yes, what? \_\_\_\_\_

Sign here to authorize x-rays and necessary tests \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past? \_\_\_\_\_

Does this condition affect your family or social life?  Yes  No

What aggravates this condition? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

What helps your symptoms? \_\_\_\_\_

Have you had any surgery, falls or accidents?  Yes  No

When? \_\_\_\_\_ Please describe \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

## INSURANCE INFORMATION

Is this condition due to:  
 A work-related injury?  Yes  No      An automobile accident?  Yes  No

If you answer yes to either of the above questions, please complete other side of form.

Do you have Major Medical Health Insurance?  Yes  No

Company \_\_\_\_\_

Address \_\_\_\_\_

Does your insurance company require a referral from your Primary Care Physician?  Yes  No

If yes, name of PCP \_\_\_\_\_ Telephone \_\_\_\_\_

## Do You Suffer From:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dudick Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dudick Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

Complete only for:

**JOB INJURY INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of accident \_\_\_\_\_  
\_\_\_\_\_

Workman's Compensation Case # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Insurance Company Case # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Address \_\_\_\_\_

Hospitalized? \_\_\_\_\_ Name of Hospital \_\_\_\_\_ X-rays taken \_\_\_\_\_

Other Doctors seen \_\_\_\_\_

Are you working now? \_\_\_\_\_

Time lost from work \_\_\_\_\_ to \_\_\_\_\_ (dates)

Complete only for:

**ACCIDENT INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

How did accident occur?  Auto Collision  Other \_\_\_\_\_

If auto accident, were you  Driver  Passenger  Pedestrian

If auto collision, were you struck from  Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other(s) involved?  Yes  No

Or did the other car strike yours?  Yes  No  Undetermined

As a result of the accident, were traffic citations issued to you?  Yes  No

To the driver of the other car?  Yes  No

To the driver of your car?  Yes  No

List the extent of the injuries as you know them \_\_\_\_\_  
\_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No

Check symptoms you have noticed since accident:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring         | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell     | <input type="checkbox"/> _____         |

Symptoms other than above \_\_\_\_\_

Have you lost any days of work?  Yes  No Dates: \_\_\_\_\_

Insurance Companies involved:

My Company \_\_\_\_\_

Company of person responsible for injuries \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?  Yes  No

Do you have an attorney that has advised you in this care?  Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone: \_\_\_\_\_



**RE: Name of Patient** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_

**SS #** \_\_\_\_\_

### **RECORDS RELEASE**

1) I hereby authorize Dudick Health to release and to permit the examination or copying of any of my medical records, X-rays, laboratory reports, and the results of all tests of any type or character to such persons as Dudick Health deems appropriate, including the information necessary to process a claim.

2) I hereby authorize my doctor or supplier of service to release and to permit the copying of any of my medical records, X-rays, insurance information, laboratory reports and the results of all tests of any type to Dudick Health, at 1789 Route 9, Clifton Park, NY 12065.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

### **ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to Dudick Health for services provided.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

### **ACCEPTANCE OF PATIENT RESPONSIBILITY**

I understand that I am financially responsible for any charges incurred at this office, including copays, deductibles, and charges denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved, including the initial visits while waiting for approval. The insurance company will review any/all documentation submitted by Dudick Health for review for medical necessity and base their approval/denial upon this documentation.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_





# Neck Index

Managed Physical Network

MPN Usa Only rev 5/7/99

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck  
Index  
Score